



# Patient Information Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_  
 Relationship to Emergency Contact: \_\_\_\_\_ Emergency Contact #: \_\_\_\_\_  
 Email (optional): \_\_\_\_\_  
 Sex:  Male  Female Marital Status:  Single  Married  Other  
 Employed:  Yes  No  Full-time Student  Part-time Student

Diagnosis: \_\_\_\_\_ Right Left Bilateral  
 Referring Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Copy of Referral:  Yes  No Fax #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Relationship to Subscriber: Spouse Child Self  
 Subscriber's DOB: \_\_\_\_\_ Subscribers Address: \_\_\_\_\_  
 Subscriber #: \_\_\_\_\_ Group # \_\_\_\_\_  
 Copy of Card in Chart:  Yes  No Insurance's Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Secondary Insurance  Yes  No

L&I Claims Only:  
 Claim Filed:  Yes  No Claim Approved:  Yes  No Claim/ID#: \_\_\_\_\_  
 Claims Manager: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

I understand, as the patient and/or above-mentioned responsible party, that I am fully responsible for payment of all charges incurred.

I authorize my insurance benefits to be paid directly to Rainwater Rehabilitation for Services rendered. I understand I am financially responsible for any deductibles, non-covered services, or non-authorized services. I am aware of the \$25.00 cancellation fee and agree to pay that amount if I do not give 24 hours notice before canceling my appointment. I authorize Rainwater Rehabilitation to release any information requested by the insurance company with regards to payment of benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## For Office Use Only:

Claim # \_\_\_\_\_  
 Type of Insurance \_\_\_\_\_ Claim opened  YES  NO  
 Pre-Authorization required  YES  NO Approved  YES  NO  
 PCP Referral required  YES  NO Referral in chart  YES  NO  
 Deductible \_\_\_\_\_ Deductible Met  YES  NO  
 Dollar/Visit Limit \_\_\_\_\_ Amount Used \_\_\_\_\_  
 Orthotic coverage \_\_\_\_\_ Copay \_\_\_\_\_  
 Calendar year: From \_\_\_\_\_ To \_\_\_\_\_ Call Log \_\_\_\_\_

Auth Date—from & to	# of Visits	Authorization #	Date Received

Date \_\_\_\_\_ Notes \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES

Effective 9/1/02

The Health Insurance Portability and Accountability act of 1995 is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us be kept properly confidential. As required by HIPAA, following is an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment – providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment – such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health care operations – include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions and customer service.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to a member of the Rainwater Rehabilitation staff.

- The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to request a copy of our current Notice of Privacy Practices at any time.

If you feel that your rights to privacy have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

**I have read and understand the above Notice of Privacy Practices and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above.**

**Signature of Patient / Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For the treatment of minors: I hereby grant permission for Occupational Therapy to be performed on this minor.**

**Patent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_